SCOTTSDALE HEALTHCARE℠
Diabetes Center

Diabetes Self-Management Program

GESTATIONAL & TYPE 1 DIABETES: PREGNANCY SELF ASSESSMENT

PLEASE ANSWER ALL QUESTIONS

General Information

Name: ______________________________ Age: ________ Date of Birth: _________

Race: ☐ Caucasian ☐ Hispanic ☐ Afro-American ☐ Asian ☐ Native American ☐ Other

Have you ever used services at Osborn or Shea Hospital? ☐ No ☐ Yes

Have you ever been educated for gestational diabetes before? ☐ No ☐ Yes If yes, how long ago? ____ years

Are you currently employed? ☐ No ☐ Yes If yes, employer? __________________________

What time do you start work ? _______ What time do you end work? ________ Type of work? _____________________

Years of school completed? ☐ 8 yrs ☐ 12 yrs ☐ college/technical ☐ advanced degree

How do you learn best? ☐ Reading ☐ Class ☐ Films ☐ Computer ☐ Participation/demonstration

Are there any language, religious, or cultural factors to consider in teaching you diabetes self-management?
☐ No ☐ Yes If yes, please explain: _________________________________

Are there any problems we should know about that would interfere with your ability to learn in a class room setting (visual, hearing, reading, language)? ☐ No ☐ Yes

If yes, please describe: ____

What are you most eager to learn about? ___________________________

Medical History

Estimated delivery date __________________ Number of weeks pregnant? __________

Are you having any problems with this pregnancy? ☐ No ☐ Yes If yes, describe ______________________________

Number of previous pregnancies________
Age of children _____, _____, _____, _____, Birth Weight _____, _____, _____, _____

Have you ever had a miscarriage or stillborn infant? ☐ No ☐ Yes

Have you had an infant that weighed over 9 pounds at birth? ☐ No ☐ Yes

Have you had a premature birth? ☐ No ☐ Yes How many weeks? _______

Did you have any complications during a previous pregnancy? If yes, please explain ________________________

Do you smoke? ☐ No ☐ Yes ☐ Recently quit

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, # ________ drinks per day/week (circle one)

Do any of your relatives have diabetes? ☐ No ☐ Yes

Do you have any allergies? ☐ No ☐ Yes If yes, list: __________, __________, __________

What time do you wake-up in the morning? ___________ What time do you go to sleep? _____________

Have you had gestational diabetes previously? ☐ No ☐ Yes If yes, did you monitor your blood sugar? ☐ No ☐ Yes

If yes, how was it treated? ☐ Diet ☐ pills ☐insulin

Medication Record Form (record insulin on last page if applicable)

Prescription medications:	Record the information written on your medicine containers)				
Name	**Dose**	**What is it for?**	**Start date**	**Amount taken**	**When taken**
(example - how to complete) *Tolinase*	*100 mg*	*diabetes*	*3/5/04*	*1 tablet*	*1 tablet once a day with breakfast*

Nonprescription medicines, vitamins, minerals, herbals & supplements currently being used (check all that apply)

☐ cold or cough medicine ☐ aspirin or other pain reliever ☐ antacids ☐ sleeping pills

☐ allergy relief medicine ☐ laxatives ☐ diet pills ____________

☐ pre-natal vitamins ____________

☐ minerals ____________, ____________, ____________, ____________

☐ other ____________, ____________, ____________, ____________

Additional information you would like me to know: ____

____

Diabetes Management Information

Blood Glucose (BG) Monitoring:

Do you currently check your BG with a blood glucose meter? ☐ No ☐ Yes If yes, meter brand ____________

How often do you test per day? ______ Usual test results ____________

Are you able to check your blood sugar at work? ☐ No ☐ Yes

Activity:

Do you get activity on a regular basis? ☐ No ☐ Yes

How much activity do you do per day? ☐ none ☐ 1 - 30 min ☐ 30 - 60 min ☐ 60+ min

What type of activity do you do? ____

Are there any medical reasons that limit you from daily activity? ☐ No ☐ Yes

If yes, please explain: ____

Nutritional Assessment

Height: _____ ft _____in Weight: Current _____lbs Weight before pregnancy: ______lbs

Do you follow any type of meal plan? ☐ No ☐ Yes If yes, describe? ________________________________

Do you skip meals? ☐ No ☐ Yes If yes, how often? ________ times per day / week (circle one)

Have you been given any diet restrictions? ☐ No ☐ Yes If yes, what? ________________________

Who prepares your meals (check all that apply)? ☐ self ☐ spouse ☐ family ☐ other ___________

How many meals per week do you eat out? ☐ 0 - 1 ☐ 2 - 4 ☐ 5 - 8 ☐ 9+

Do you ever: ☐ binge ☐ purge ☐ use laxatives frequently

Nutritional Assessment (Cont.)

Do you typically eat breakfast? ☐ Yes ☐ No What time: ________
Describe items from a typical breakfast including: how much you eat, condiments you use and drinks.

Do you typically eat lunch? ☐ Yes ☐ No What time: ________
Describe items from a typical lunch including: how much you eat, condiments you use and drinks.

Do you typically eat dinner? ☐ Yes ☐ No What time: ________
Describe items from a typical dinner including: how much you eat, condiments you use and drinks.

Do you snack between meals: ☐ Yes ☐ No **If yes, what time:** ______ morning _____ afternoon _____ bedtime

Describe typical snacks? ____

Who prepares your meals? (check all that apply) ☐ Self ☐ Spouse ☐ Family ☐ Other

How many times per week do you eat out? ☐ 0 - 1 ☐ 2 - 4 ☐ 5 - 8 ☐ 9+

How often do you drink the following:

Milk ☐ Daily ☐ Weekly ☐ Monthly ☐ Never What kind? ________________ How much?_______

Beer, wine, distilled spirits ☐ Daily ☐ Weekly ☐ Monthly ☐ Never What kind? ________________ How much?_______

Soda ☐ Daily ☐ Weekly ☐ Monthly ☐ Never How much?_______ ☐ Regular ☐ Diet

Patient's Signature: ____ Date: ___________

Daytime phone number _______________________ Email address ____________________ @ _________________

May we contact you with more Diabetes Center information or leave messages on your email? ☐ Yes ☐ No

- -

For Diabetes Center:

Assessment reviewed by: ____________________________________ _____________

____________________________________ _____________

Notes:

Complete this page only if you are taking insulin.

Insulin Medication Record Form

Please list the insulin you are taking:

INSULIN TYPE	# OF UNITS	TIME OF DAY

Do you adjust your own insulin dosages? ☐ No ☐ Yes

If yes, did your doctor give you a scale to use? ☐ No ☐ Yes If so, what is the scale? ____

____

____

What size syringe do you use? ☐ 1cc (100 units) ☐ 1/2cc (50 units) ☐ 3/10cc (30 units)

Do you use an insulin pump? ☐ No ☐ Yes

Have you ever used an insulin pen? ☐ No ☐ Yes

Who gives you your injections? _________________, __________________

Do you use any special injection aids or devices? ☐ No ☐ Yes

If yes, what? ______________, ________________, _______________

What area/s do you use for insulin injections? ____________, ____________, ____________

Does insulin or blood ever come out of the injection site? ☐ No ☐ Yes If yes, how often?____________

How do you dispose of your syringes and lancets ____________________________________

Where do you store your extra insulin bottles? _________________________

How do you store the bottle you are currently using? _________________________

Do you ever leave your insulin in your car? ☐ No ☐ Yes

Do you keep glucagon at home? ☐ No ☐ Yes

Do you check your urine for ketones? ☐ No ☐ Yes If yes, when? ______________

Are you able to sense low blood sugar reactions? ☐ No ☐ Yes

Notes: